WRITTEN TESTIMONY

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I submit this formal testimony to the State of Connecticut regarding the systemic and sustained failure of the Connecticut Department of Correction, as documented in the 2025 Conditions of Confinement Report issued by the Office of the Correction Ombuds.

This testimony is submitted in the interest of calling for meaningful change and affirming the fundamental principles of safety, dignity, and access to adequate healthcare for all incarcerated people in the State of Connecticut.

The report makes clear that the challenges within our correctional system are not isolated incidents or temporary disruptions. They are structural failures that have become normalized through inaction, weak governance, and the absence of enforceable standards.

Chronic understaffing has driven the Department to rely on routine lockdowns as a management tool rather than an emergency response. These lockdowns predictably occur during weekends, holidays, and known staffing shortages. During these periods, incarcerated individuals are denied medical care, mental health services, showers, hygiene, visitation, recreation, programming, and access to legal resources. Connecticut has no enforceable minimum staffing standards and no limits on non-emergency lockdowns. This represents a policy failure.

Medical and mental health care represent the largest category of complaints. The report documents delayed diagnoses, interrupted continuity of care following transfers, prolonged specialty-care backlogs, inadequate intake screening, and failure to identify or accommodate disabilities. Independent oversight confirms that individuals with disabilities and youth are disproportionately harmed. Delayed care does not reduce costs; it increases preventable harm, long-term expenses, and legal exposure.

Conditions within facilities raise serious public health concerns. Mold, rodent infestations, sewage backups, broken showers, lack of hygiene supplies, and extreme heat have been documented across multiple institutions. These conditions undermine human dignity and endanger incarcerated individuals and correctional staff alike.

Food services further compound these failures. Complaints of spoiled food, inadequate portions, and failure to meet medical diets undermine health, worsen chronic illness, and erode basic dignity.

Access to legal services has broken down to such an extent that the Office of the Correction Ombuds was forced to initiate enforcement litigation simply to obtain records from a state contractor. When oversight must litigate to perform its statutory role, transparency has failed.

State audits repeatedly identify the same governance and fiscal control failures year after year, including overtime abuse, payroll weaknesses, asset mismanagement, and noncompliance with statutory reporting requirements. The issue is not lack of warning, but lack of corrective action.

The Department reported 33 in-custody deaths in 2024 and 22 in 2025. These deaths must be viewed in the context of delayed care, lockdowns, limited observation, and chronic understaffing.

The Office of the Correction Ombuds is clear: these conditions are foreseeable, preventable, and correctable. What is missing are enforceable staffing standards, limits on non-emergency lockdowns, mandatory service-continuity requirements, transparent health-care metrics, and fully resourced independent oversight.

I respectfully urge the Judiciary Committee and the General Assembly to act decisively. Connecticut must commit to a correctional system that prioritizes safety, dignity, and access to healthcare, not only to meet constitutional obligations, but to uphold our shared values as a state.

Failure to act is a choice to accept the current outcomes. The cost of reform is real, but the cost of inaction—human, legal, and fiscal —is far greater.